The Administration of Electro-Convulsive Therapy in Approved Centres
Activity Report 2021
November 2022
TABLE OF CONTENTS

List of tables ........................................................................................................................................... 2
List of figures ............................................................................................................................................ 2
Glossary .................................................................................................................................................... 3
Summary .................................................................................................................................................... 4
1. Introduction ........................................................................................................................................... 6
2. About the data ....................................................................................................................................... 8
   2.1 Data coverage .................................................................................................................................... 9
   2.2 Data collection .................................................................................................................................... 9
   2.3 Data limitations ............................................................................................................................... 9
   2.4 Admissions to approved centres ................................................................................................. 10
3 ECT activity data .................................................................................................................................. 11
   3.1 Programmes and treatments ....................................................................................................... 12
   3.2 ECT services .................................................................................................................................... 14
   3.3 People receiving ECT ..................................................................................................................... 17
   3.4 Administration of ECT treatment without consent ..................................................................... 18
   3.5 Reasons for and outcomes of ECT use ....................................................................................... 19
4. Compliance with ECT Rules and Code of Practice ........................................................................... 22
Discussion ............................................................................................................................................... 25
Conclusion ............................................................................................................................................... 31
References ............................................................................................................................................... 33
Appendix 1: CIS215 - ECT notification screen and Form 16 ................................................................. 37
Appendix 2: ICD 10 Codes and Diagnostic Groups ............................................................................ 41
Notes ....................................................................................................................................................... 42
LIST OF TABLES

Table 1: Number of approved centres ................................................................. 9
Table 2: Total admissions and involuntary admissions ....................................... 10
Table 3: Overview of ECT administration: residents, programmes and treatments ................................................................. 12
Table 4: Treatments per programme of ECT ..................................................... 12
Table 5: Average ECT programme duration ..................................................... 14
Table 6: Overview of approved centres using ECT ......................................... 14
Table 7: Programmes of ECT reported by each approved centre ...................... 15
Table 8: Programmes of ECT by residents’ legal status .................................... 18
Table 9: Programmes of ECT with change in legal status ............................... 18
Table 10: Programmes of ECT with one or more treatments without consent .... 18
Table 11: Indications for ECT ........................................................................... 20
Table 12: Reason for ending programme of ECT ............................................ 20
Table 13: Outcome at end of ECT programme ................................................ 21
Table 14: Laterality of ECT programmes .......................................................... 21

LIST OF FIGURES

Figure 1: Number of programmes of ECT administered to residents .............. 13
Figure 2: Number of treatments per programme ............................................ 13
Figure 3: Gender of residents who were administered ECT ............................ 17
Figure 4: Age range by gender of residents who were administered ECT ........ 17
Figure 5: Programmes of ECT by diagnosis .................................................. 19
Figure 6: Relevant approved centre compliance with Rules Governing the Use of Electro-Convulsive Therapy, 2019 – 2021 .............................................. 23
Figure 7: Relevant approved centre compliance with Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, 2019 – 2021 .... 24
Figure 8: Comparison of number of residents and programmes in approved centres, 2008–2021 ................................................................. 26
Figure 9: Comparison of number of ECT treatments per year, 2008–2021 ........ 27
Figure 10: Comparison of total admissions to involuntary admissions, 2008–2021 ................................................................. 27
Figure 11: Comparison of gender of residents who were administered ECT, 2008–2021 ......................................................................................... 28
Figure 12: Comparison of indications for use of ECT, 2008–2021 .................... 28
Figure 13: Comparison of programmes of ECT by diagnosis, 2008–2021 ......... 29
Figure 14: Comparison of outcomes of ECT treatment, 2008–2021 ................ 30
Figure 15: Comparison of average age of ECT residents, 2008–2021 ............... 30
GLOSSARY

Approved centre is a hospital or other inpatient facility for the care and treatment of persons suffering from mental illness or mental disorder which is registered pursuant to the Mental Health Acts 2001-2018. The Mental Health Commission (MHC) establishes and maintains the Register of Approved Centres pursuant to the 2001 Act.

Code of Practice refers to the Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, prepared by the MHC in accordance with Section 33(3)(e) of the Mental Health Act 2001-2018.

Community Healthcare Organisations (CHO) were established by the Health Service Executive in 2015 to deliver health services at a local level across both the statutory and voluntary sectors in the community setting, in partnership with the National Primary Care, Social Care, Mental Health, and Health and Wellbeing Divisions. A list of approved centres in each of the nine CHOs is available in Table 7.

Electro-Convulsive therapy (ECT) is a medical procedure in which an electric current is passed briefly through the brain via electrodes applied to the scalp to induce generalised seizure activity. The person receiving treatment is placed under general anaesthetic and muscle relaxants are given to prevent body spasms. Its purpose is to treat specific types of major mental illnesses.

Involuntary patient is a person to whom an admission or renewal order relates. The term ‘patient’ is to be construed in accordance with Section 14 of the Mental Health Act 2001-2018.

Maintenance ECT (also referred to as continuation ECT) is defined as ECT usually delivered at intervals of between one week and three months, which is designed to prevent relapse of illness. The purpose of maintenance ECT is to give the treatments as infrequently as possible, while preventing a relapse of symptoms (ECT Accreditation Service, 2017).

Mental illness means a state of mind of a person which affects the person’s thinking, perception, emotion or judgement and which seriously impairs the mental function of the person, to the extent that he or she requires care or medical treatment.

Programme of ECT refers to no more than 12 treatments prescribed by a consultant psychiatrist.

Resident means a person receiving care and treatment in an approved centre. For the purpose of this report, the term ‘resident’ includes involuntary patients, voluntary patients and individuals who were administered ECT on an outpatient or day-patient basis in an approved centre.

Rules refer to the Rules Governing the Use of ECT, made by the MHC in accordance with Section 59(2) of the Mental Health Act 2001-2018.

Voluntary patient is a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order.
# ACTIVITY SUMMARY 2021

All figures included in this summary are calculated across 2021 and 2020, unless otherwise indicated.

## Programmes and treatments of ECT

Approved centres reported that 293 **programmes of ECT** were administered to 219 residents in 2021, compared to 300 programmes of ECT administered to 239 residents in 2020.

A total of 2,281 individual treatments of ECT were administered in 2021, a small decrease in comparison to 2020 (2,329).

The rate of ECT programmes per resident was **1.3 programmes** in both 2021 and 2020.

In 2021, 74% of residents received only a single programme of ECT, compared to 70% in 2020.

A programme of ECT may involve up to 12 individual treatments of ECT. The average number of treatments per programme was **7.8** in both 2021 and 2020.

## Services providing ECT

**Sixteen** approved centres (24%) provided an ECT service in 2021, an increase from 14 approved centres (23%) in 2020.

A further **13** approved centres (19%) reported that they referred residents to another approved centre for ECT treatment in 2021, compared to **5** approved centres (8%) in 2020.

In 2021, all applicable services (100% of those administering ECT to involuntary patients) were compliant with the Rules Governing the Use of ECT, an increase from 77% compliance in 2020.

All relevant services (100%) were compliant with the Code of Practice on the Use of ECT in 2021, an increase from 86% compliance in 2020.
Mood (affective) disorders involve a change in mood either to depression (with or without anxiety) or to elation. The mood change is usually accompanied by a change in overall level of activity. Mood disorders tend to be recurrent and the onset of individual episodes can often be related to stressful events or situations (ICD-10, 2019).

In 2021, the average age of all residents who were administered ECT was 65 years, an increase from an average of 62 years in 2020. In 2021, residents receiving ECT ranged in age from 23 to 94 years, compared to 25 to 93 years in 2020.

Data from recent years indicate that female residents are more likely to be administered ECT than males. **Fifty-nine percent (59%) of ECT residents in 2021 were female.** The higher ratio of female to male ECT recipients may reflect the relatively higher incidence of depressive illness in women as compared with men.

In 2021, 82% of residents were admitted on a voluntary basis when they commenced their programme of ECT, compared to 78% in 2020.

In 2021, 87% of ECT treatments (1,985) were administered with consent, and 13% (296) were administered without consent. In 2020, 81% of treatments (1,881) were administered with consent, and 19% of treatments (442) were administered without consent.

In 2021, 5% of residents (15) withdrew consent during the course of their programme of ECT, in line with 2020 (5%, 16 residents).

**Reasons for and outcomes of ECT**

Mood disorders\(^1\) (including depression) were reported as a diagnosis for 87% of residents who were administered ECT in 2021, compared to 80% of residents in 2020.

Improvement was reported as the outcome in 87% of programmes of ECT (256) in 2021, compared to 63% in 2020 (189). Outcome information was not provided for 11 programmes (4%) in 2021.

---

\(^1\) Mood (affective) disorders involve a change in mood either to depression (with or without anxiety) or to elation. The mood change is usually accompanied by a change in overall level of activity. Mood disorders tend to be recurrent and the onset of individual episodes can often be related to stressful events or situations (ICD-10, 2019).
Chapter 1

Introduction
INTRODUCTION

The Mental Health Commission (MHC) is the regulator for mental health services in Ireland. The MHC is an independent statutory body established in 2002. Its primary functions are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to protect the interests of persons admitted and detained under the Mental Health Acts 2001-2018 (the 2001 Act).

One of the core elements of the MHC’s mission is to regulate and engage to promote, support, and uphold the rights, health and wellbeing of all people who access mental health services. The use of electro-convulsive therapy (ECT) in Ireland is regulated by the 2001 Act. This report provides information on how often ECT is used, the people who receive it, the services providing it, and the quality and safety of the service.

In addition, the ECT Accreditation Scheme (ECTAS) was established in 2003 by the Royal College of Psychiatrists to support quality improvement of ECT clinics in both Ireland and the UK. The ECTAS standards have been developed for the purposes of review and accreditation of ECT centres, and there is also a guide for new or developing ECT services (Royal College of Psychiatrists, 2020). It should be noted that three ECTAS-accredited centres in Ireland delivered 64% of ECT programmes in both 2021 and 2020. While the MHC does not require approved centres to be ECTAS accredited in order to carry out ECT treatment, ECTAS is nevertheless recognised by the MHC as best practice, and all approved centres are encouraged to become ECTAS accredited in the future.

This report describes the administration of ECT in 2021 nationally, by sector (by Community Healthcare Organisations (CHOs) and independent service providers), and by individual service.

The MHC would like to thank staff in approved centres for their ongoing cooperation in relation to the collation and return of ECT data, which has enabled this report to be completed. For the majority of services using ECT, the collation of this data is a manual process, and the MHC appreciates the local commitment required to report this data on an annual basis.

As per the 2001 Act, ECT may be administered to an involuntary patient without consent only where it has been determined that the patient is unable to consent to the treatment (see Section 3.4).

The MHC issued revised (Version 3) Rules Governing the Use of Electro-Convulsive Therapy (Mental Health Commission, 2016b) and a revised Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients (MHC, 2016c) in February 2016 to reflect the legislative change and to align with current best international practice.

This report describes the administration of ECT in 2021 nationally, by sector (by Community Healthcare Organisations (CHOs) and independent service providers), and by individual service.

The MHC would like to thank staff in approved centres for their ongoing cooperation in relation to the collation and return of ECT data, which has enabled this report to be completed. For the majority of services using ECT, the collation of this data is a manual process, and the MHC appreciates the local commitment required to report this data on an annual basis.

In early 2020, the MHC initiated roll-out of its online Comprehensive Information System (CIS) ECT function, which aimed at gathering better data about the use of ECT in approved centres. The implementation of the CIS ECT function alters the obligation on approved centres from providing an annual data return of all programmes of ECT to providing a contemporaneous data entry for each ECT treatment.
Chapter 2

About the data
### ABOUT THE DATA

#### 2.1 Data coverage

Data are presented for all approved centres that were entered on the Register of Approved Centres during 2019, 2020 and 2021. Table 1 reflects the number of approved centres on the Register at any time during the reporting year, including new registrations and closures.

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved centres</td>
<td>65</td>
<td>66</td>
<td>67</td>
</tr>
<tr>
<td>Approved centres using ECT</td>
<td>18</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>Approved centres referring residents for ECT</td>
<td>14</td>
<td>5</td>
<td>13</td>
</tr>
</tbody>
</table>

#### 2.2 Data collection

The Rules and Code of Practice on the use of electro-convulsive therapy require that the ECT Register be completed for the resident on conclusion of a programme of ECT and a copy filed in the resident’s clinical file. As a programme of ECT may have been commenced in one year and completed in another, each programme is counted in the year in which it was concluded, as this is when the ECT Register is completed in full.²

In 2021, data on administration of ECT were reported to the MHC from approved centres via the MHC’s online CIS ECT function, the first year that all ECT notifications were submitted electronically.

#### 2.3 Data limitations

Data limitations as outlined below should be considered:

- Approved centres varied in relation to the number of beds and the type of service provided.
- Comparisons between programmes of ECT in individual approved centres, and in previous years, should be interpreted with caution. (For information regarding individual services, see Table 7, and the approved centre inspection reports, which can be accessed at mhcirl.ie/what-we-do/regulation/approved-centres).
- A high proportion of ECT was administered in approved centres operated by independent service providers, which provide a national service. Resident home addresses were not collected; therefore, it was not possible to re-distribute data relating to those who received ECT treatment in independent approved centres to their own HSE CHO area. For these reasons, the rates of ECT administration per CHO were not included in the current report.
- Data on the administration of ECT were submitted manually by services using the CIS ECT function, and then manually assessed by the MHC, which limited what could reasonably be requested from services and reported on.
- Results may be skewed by a small number of residents with relatively high numbers of treatments and/or programmes.
- In the absence of a national individual health identifier, it is possible that residents may be counted more than once, if they were resident in more than one approved centre, such as within their CHO and subsequently in an independent service, within the same year. The exception is where residents have been referred from one approved centre to another for ECT – this is recorded and accounted for.

---

² A period of time may elapse between the date of last treatment and the date when the Register is completed in full, and in some cases these dates fall into different years. For example, the date of last treatment may have been in December 2020 but the information regarding reason for ending a programme of ECT and the outcome for that programme may not have been completed until January 2021. Some approved centres have indicated that they report such programmes of ECT in the year in which the Register was completed in full rather than the date of last treatment.
• Approved centres submitting an ECT notification online using the CIS function are requested to enter the name of each approved centre that referred a resident to them for a programme of ECT, if applicable. The MHC uses this field to determine the number of approved centres that refer residents for ECT treatment.

2.4 Admissions to approved centres

Information regarding admissions activity to approved centres nationally is included here to provide context in relation to the administration of ECT in approved centres. Table 2 shows that there were 15,723 admissions nationally in 2021 and 15,391 in 2020. Data on involuntary admissions (including admissions from the community and re-grades of patients from voluntary to involuntary) shows that involuntary admissions accounted for 17% of admissions in 2021, an increase on 2020 (16%).

The Health Research Board reported that in 2021 and 2020, depressive disorders were the most common diagnoses recorded, accounting for 23% and 24% respectively of all admissions to inpatient mental health services. In addition, schizophrenia accounted for 21% and 22% of all admissions in 2021 and 2020 respectively.

In 2021, 51% of service users admitted to mental health services were female, compared to 50% in 2020. In both 2021 and 2020, females had a higher rate of hospitalisation for depressive disorders than males, while males had a higher rate of hospitalisation for schizophrenia (Daly and Craig, 2020; Daly and Craig, 2021).

Table 2: Total admissions and involuntary admissions

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total admissions</td>
<td>16,710</td>
<td>15,391</td>
<td>15,723</td>
</tr>
<tr>
<td>Involuntary admissions</td>
<td>2,390</td>
<td>2,463</td>
<td>2,673</td>
</tr>
</tbody>
</table>

3 Data are sourced from the Health Research Board’s ‘Activities of Irish Psychiatric Units and Hospitals 2019’ (Daly and Craig, 2020), ‘Annual Report on the Activities of Irish Psychiatric Units and Hospitals 2020’ (Daly and Craig, 2021) and ‘Annual Report on the Activities of Irish Psychiatric Units and Hospitals 2021’ (Daly and Craig, 2022).
ECT activity data
ECT ACTIVITY DATA

3.1 Programmes and treatments

Data are presented for 2021 and 2020, with 2019 and 2018 data included for context where relevant. Data on the number of programmes of ECT administered are presented nationally, by sector (by CHO and independent service provider), and in relation to each individual approved centre.

Total residents, programmes and treatments

Table 3 outlines the total number of residents who were administered ECT, the total number of ECT programmes, and the total number of administered treatments of ECT.

In 2021, 219 residents were administered one or more programmes of ECT. In total, 296 programmes of ECT were administered. The number of treatments within a programme ranged from 1 to 12 treatments, with 2,291 treatments of ECT being administered in total, resulting in an average of 7.7 treatments per programme. In 2020, 239 residents were administered one or more programmes of ECT, for a total of 300 programmes. The number of treatments similarly ranged from 1 to 12 treatments, with 2,329 treatments being administered in total. The average number of treatments per programme in 2020 was 7.8, slightly higher than in 2021.

Table 3: Overview of ECT administration: residents, programmes and treatments

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents administered ECT</td>
<td>286</td>
<td>239</td>
<td>219</td>
</tr>
<tr>
<td>Programmes of ECT administered</td>
<td>395</td>
<td>300</td>
<td>296</td>
</tr>
<tr>
<td>Total treatments of ECT administered</td>
<td>3,124</td>
<td>2,329</td>
<td>2,291</td>
</tr>
</tbody>
</table>

Table 3 indicates that the number of residents receiving ECT has been reducing year on year.

Programmes per resident

Figure 1 shows that the majority of residents were administered one programme of ECT (73.5% in 2021 and 70.0% in 2020). In 2021, 20.5% of residents were administered two programmes of ECT, followed by 5.9% who were administered three or more programmes. In 2020, 22.0% of residents were administered two programmes of ECT, with 8.0% being administered three or more programmes.

Treatments per programme of ECT

A programme of ECT refers to no more than 12 treatments of ECT prescribed by a consultant psychiatrist, with the total number of treatments administered in a programme of ECT varying from 1 to 12 treatments. Table 4 shows that the average number of treatments per programme was approximately eight between 2019 and 2021.

Table 4: Treatments per programme of ECT

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of treatments per programme</td>
<td>7.9</td>
<td>7.8</td>
<td>7.7</td>
</tr>
<tr>
<td>Programmes of 12 treatments</td>
<td>102</td>
<td>64</td>
<td>68</td>
</tr>
<tr>
<td>Programmes of one treatment</td>
<td>11</td>
<td>13</td>
<td>8</td>
</tr>
</tbody>
</table>

Most programmes of ECT (97.3% in 2021 and 95.7% in 2020) involved more than one treatment. The number of treatments prescribed, the resident’s diagnosis, indications for ECT, response to treatment and outcome may all be factors that account for variation in the number of ECT treatments.

The most frequent number of treatments per programme was the maximum of 12, which accounted for 23.0% of all programmes in 2021, compared to 21.3% in 2020. The distribution in the number of treatments per programme can be seen in Figure 2.
**Figure 1: Number of programmes of ECT administered to residents**

- One Programme of ECT
- Two programmes of ECT
- Three or more programmes of ECT

<table>
<thead>
<tr>
<th>Year</th>
<th>One Programme</th>
<th>Two Programmes</th>
<th>Three or More Programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>74.3%</td>
<td>18.6%</td>
<td>7.1%</td>
</tr>
<tr>
<td>2019</td>
<td>72.7%</td>
<td>15.7%</td>
<td>11.6%</td>
</tr>
<tr>
<td>2020</td>
<td>70.0%</td>
<td>22.0%</td>
<td>8.0%</td>
</tr>
<tr>
<td>2021</td>
<td>73.5%</td>
<td>20.5%</td>
<td>5.9%</td>
</tr>
</tbody>
</table>

**Figure 2: Number of treatments per programme**

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of ECT Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>100%</td>
</tr>
<tr>
<td>2019</td>
<td>90%</td>
</tr>
<tr>
<td>2020</td>
<td>80%</td>
</tr>
<tr>
<td>2021</td>
<td>70%</td>
</tr>
</tbody>
</table>

Mental Health Commission | 2022
Duration of a programme of ECT
As previously discussed, the Rules and Code of Practice on the use of ECT specify the maximum number of treatments in a programme of ECT, but do not prescribe a timeframe or duration for a programme of ECT. Data reported to the MHC indicate that the length of time over which a programme of ECT is administered to a resident varies considerably.

Table 5 provides an overview of average ECT programme duration between 2019 and 2021, showing that the average duration of all ECT programmes was 46 days in 2021, and 42 days in 2020. The average duration of programmes of maintenance ECT was 110 days in 2021, and 115 days in 2020, while the average duration for ECT programmes to treat urgent or acute issues was 32 days in both 2021 and 2020. Given the distinctly different purposes of maintenance and acute ECT, the disparity in the average duration between maintenance and acute programmes (a ratio of approximately three-to-one) is explainable.

Table 5: Average ECT programme duration

<table>
<thead>
<tr>
<th>ECT programme type</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>All programmes</td>
<td>44</td>
<td>42</td>
<td>46</td>
</tr>
<tr>
<td>Maintenance ECT</td>
<td>110</td>
<td>115</td>
<td>110</td>
</tr>
<tr>
<td>Maintenance ECT excluded</td>
<td>35</td>
<td>32</td>
<td>32</td>
</tr>
</tbody>
</table>

3.2 ECT services
ECT in approved centres
Table 6 provides an overview of the number of approved centres that administered ECT over the five-year period from 2017 to 2021. In 2021, 38 (57%) approved centres did not provide an ECT service (either directly or by referral to another service), 16 (24%) services provided an ECT service, and 13 (19%) centres referred residents to another approved centre for ECT treatment.

Table 6: Overview of approved centres using ECT

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECT service</td>
<td>16</td>
<td>15</td>
<td>17</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>25.0%</td>
<td>23.1%</td>
<td>26.2%</td>
<td>21.2%</td>
<td>23.9%</td>
</tr>
<tr>
<td>ECT service by referral</td>
<td>8</td>
<td>15</td>
<td>14</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>12.5%</td>
<td>23.1%</td>
<td>21.5%</td>
<td>7.6%</td>
<td>19.4%</td>
</tr>
<tr>
<td>No ECT service</td>
<td>40</td>
<td>35</td>
<td>34</td>
<td>47</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>62.5%</td>
<td>53.8%</td>
<td>52.3%</td>
<td>71.2%</td>
<td>56.7%</td>
</tr>
<tr>
<td>Total approved centres</td>
<td>64</td>
<td>65</td>
<td>65</td>
<td>66</td>
<td>67</td>
</tr>
</tbody>
</table>

Administration of ECT by approved centre and CHO area
This section includes data in relation to the administration of ECT in individual approved centres. Data are presented nationally, by sector (by CHO or national provider) and by individual approved centre.

Table 7 shows the number of programmes of ECT reported by each approved centre in 2021, with 2020 and 2019 data included for context. The approved centres are ordered by sector (by CHO or national provider). Given the sensitive and potentially identifiable nature of the data, if fewer than five programmes of ECT were reported by an approved centre, ‘<5’ is used in the table.

All 9 CHO areas had at least one approved centre that reported one or more programmes of ECT in the period spanning 2019 to 2021. The Central Mental Hospital (NFMHS), St Joseph’s ID Service (NIDS), and all Child and Adolescent Mental Health Services (CAMHS) did not report any programmes of ECT during the three-year period.

Acute Psychiatric Unit, Tallaght University Hospital reported the highest number of programmes of ECT in a HSE-operated service in 2021 (32), 2020 (23) and 2019 (38); an average of 31 ECT programmes each year. In comparison, the average number of ECT programmes per year across each of the other HSE services was eight.

In relation to the Independent Services, St Patrick’s University Hospital, a large 241-bed andECTAS-accredited service, accounted for 54% of all programmes (157) in 2021. Similarly, the approved centre accounted for 53% and 50% of programmes in 2020 and 2019 respectively. In addition, 87% of residents who received ECT treatment in St Patrick’s University Hospital in 2021 were registered as private patients, compared to 13% of treatments which were accessed by public patients. St Patrick’s University Hospital has an arrangement with the HSE for the admission of residents for ECT treatment. As part of this arrangement, residents are admitted to St Patrick’s University Hospital, and therefore all such programmes are reported under this service’s figures. However, the data suggests that private patients admitted to independent services in Ireland have greater access to ECT treatment compared to public patients in the HSE.

In 2021, 18 of the approved centres (62%) either using ECT or referring residents to other services for treatment reported fewer than five programmes, an increase from 9 centres in 2020 (47%). Four services accounted for 82% of all ECT programmes in 2021. St Patrick’s University Hospital, APU Tallaght Hospital, AAMHU Galway University Hospital and St John of God Hospital. Each of these services with the exception of St John of God Hospital had ECTAS...
accreditation or were members of the network in 2021, indicating the continued move towards ECT administration in specialist centres in Ireland. The MHC has also contacted all non-ECTAS accredited approved centres requesting assurances that they are and will continue to provide a high-quality service and standards in terms of the administration of ECT.

*Table 7: Programmes of ECT reported by each approved centre*

<table>
<thead>
<tr>
<th>Approved centres by area / sector</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHO Area 1 – Population 394,333 – Donegal, Sligo/Leitrim/West Cavan, Cavan/Monaghan</strong></td>
<td>Administration</td>
</tr>
<tr>
<td>Acute Psychiatric Unit, Cavan General Hospital</td>
<td>ECT service</td>
</tr>
<tr>
<td>Department of Psychiatry, Letterkenny University Hospital</td>
<td>ECT service</td>
</tr>
<tr>
<td>Adult Mental Health Unit, Sligo University Hospital</td>
<td>ECT service</td>
</tr>
<tr>
<td><strong>CHO Area 2 – Population 453,109 – Galway, Roscommon, Mayo</strong></td>
<td>Administration</td>
</tr>
<tr>
<td>Acute Adult Mental Health Unit, University Hospital Galway</td>
<td>ECT service</td>
</tr>
<tr>
<td>Adult Mental Health Unit, Mayo University Hospital</td>
<td>ECT service</td>
</tr>
<tr>
<td>Department of Psychiatry, Roscommon University Hospital</td>
<td>By referral¹²³</td>
</tr>
<tr>
<td><strong>CHO Area 3 – Population 384,998 – Clare, Limerick, North Tipperary/East Limerick</strong></td>
<td>Administration</td>
</tr>
<tr>
<td>Acute Psychiatric Unit 5B, University Hospital Limerick</td>
<td>ECT service</td>
</tr>
<tr>
<td>Acute Psychiatric Unit 5B, University Hospital Limerick</td>
<td>By referral¹</td>
</tr>
<tr>
<td><strong>CHO Area 4 – Population 690,575 – Kerry, North Cork, North Lee, South Lee, West Cork</strong></td>
<td>Administration</td>
</tr>
<tr>
<td>Units 2, 3, 4, 5 and Unit 8 (Floor 2), St Stephen’s Hospital, Cork</td>
<td>By referral¹</td>
</tr>
<tr>
<td>South Lee Mental Health Unit, Cork UH</td>
<td>By referral¹</td>
</tr>
<tr>
<td>AMHU, Cork University Hospital</td>
<td>By referral¹</td>
</tr>
<tr>
<td><strong>CHO Area 5 – Population 510,333 – South Tipperary, Carlow/Kilkenny, Waterford, Wexford</strong></td>
<td>Administration</td>
</tr>
<tr>
<td>Department of Psychiatry, St Luke’s Hospital</td>
<td>ECT service</td>
</tr>
<tr>
<td>Grangemore Ward &amp; St Aidan’s Ward, St Otteran’s Hospital</td>
<td>By referral¹</td>
</tr>
<tr>
<td>Department of Psychiatry, University Hospital Waterford</td>
<td>ECT service¹</td>
</tr>
<tr>
<td><strong>CHO Area 6 – Population 388,297 – Wicklow, Dun Laoghaire, Dublin South East</strong></td>
<td>Administration</td>
</tr>
<tr>
<td>Elm Mount Unit, St Vincent’s University Hospital</td>
<td>ECT service</td>
</tr>
<tr>
<td>Elm Mount Unit, St Vincent’s University Hospital</td>
<td>By referral¹</td>
</tr>
<tr>
<td>Avonmore &amp; Glencree Units, Newcastle Hospital</td>
<td>By referral¹²³</td>
</tr>
<tr>
<td><strong>CHO Area 7 – Population 702,586 – Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West</strong></td>
<td>Administration</td>
</tr>
<tr>
<td>Acute Psychiatric Unit, Tallaght Hospital</td>
<td>ECT service</td>
</tr>
<tr>
<td>Jonathan Swift Clinic, St James’s Hospital</td>
<td>By referral¹²³</td>
</tr>
<tr>
<td>Lakeview Unit, Naas General Hospital</td>
<td>ECT service</td>
</tr>
</tbody>
</table>
## Approved centres by area / sector

### CHO Area 8 – Population 616,229 – Laois/Offaly, Longford/Westmeath, Louth, Meath

<table>
<thead>
<tr>
<th>Centre</th>
<th>Administration</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Psychiatry, Midland Regional Hospital, Portlaoise</td>
<td>ECT service</td>
<td>6</td>
<td>5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>St Loman’s Hospital, Mullingar</td>
<td>ECT service</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>8</td>
</tr>
<tr>
<td>HSE Navan General Hospital</td>
<td>By referral(^1)</td>
<td>0</td>
<td>0</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Laois/Offaly Community Mental Health Service</td>
<td>By referral(^1)</td>
<td>0</td>
<td>0</td>
<td>&lt;5</td>
</tr>
<tr>
<td>St Bridget’s Ward &amp; St Marie Goretti’s Ward, Cluain Lir Care Centre</td>
<td>By referral(^1,2)</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
</tbody>
</table>

### CHO Area 9 – Population 621,405 – Dublin North, Dublin North Central, Dublin North West

<table>
<thead>
<tr>
<th>Centre</th>
<th>Administration</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Psychiatry, Connolly Hospital</td>
<td>By referral(^1)</td>
<td>&lt;5</td>
<td>0</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Ashlin Centre</td>
<td>By referral(^1)</td>
<td>0</td>
<td>0</td>
<td>&lt;5</td>
</tr>
<tr>
<td>O’Casey Rooms</td>
<td>By referral(^1)</td>
<td>&lt;5</td>
<td>0</td>
<td>&lt;5</td>
</tr>
</tbody>
</table>

### Forensic Service – National Coverage

<table>
<thead>
<tr>
<th>Centre</th>
<th>Administration</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Mental Hospital</td>
<td>By referral</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Independent – National Coverage

<table>
<thead>
<tr>
<th>Centre</th>
<th>Administration</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>St John of God Hospital &amp; Cluain Mhuire(^4)</td>
<td>ECT service</td>
<td>41</td>
<td>23</td>
<td>25</td>
</tr>
<tr>
<td>St Patrick’s University Hospital</td>
<td>ECT service</td>
<td>197</td>
<td>159</td>
<td>157</td>
</tr>
<tr>
<td>Total all approved centres</td>
<td></td>
<td>395</td>
<td>300</td>
<td>293</td>
</tr>
</tbody>
</table>

**Note: population figures taken from 2016 Census of Population, CSO.ie**

\(^1\) In 2019: (i) Acute Mental Health Unit, Cork University Hospital; Department of Psychiatry; Connolly Hospital; St Aloysius, Mater Misericordiae Hospital; O’Casey Rooms, Fairview; St Edmundsbury Hospital; St Stephen’s Hospital, Cork; St Vincent’s Hospital, Fairview; and Department of Psychiatry, Waterford University Hospital all referred residents to St Patrick’s University Hospital for ECT treatment; (ii) Department of Psychiatry, Roscommon University Hospital referred residents to AAMHU Galway; (iii) Haywood Lodge referred residents to Department of Psychiatry, St Luke’s Hospital; (iv) Newcastle Hospital referred residents to Elm Mount Unit and; (v) Cluain Lir referred residents to St Loman’s Hospital.

\(^2\) In 2020: (i) Jonathan Swift Clinic, St James’ Hospital referred residents to APU Tallaght Hospital; (ii) DOP, Roscommon University Hospital to AAMHU; University Hospital Galway; (iii) Newcastle Hospital to Elm Mount Unit, St Vincent’s University Hospital; (iv) Haywood Lodge to DOP, St Luke’s Hospital and; (v) Cluain Lir to St Loman’s Hospital.

\(^3\) In 2021: (i) DOP, Roscommon University Hospital referred residents to AAMHU, University Hospital Galway; (ii) Avonmore & Glencree Units, Newcastle Hospital referred residents to Elm Mount Unit, St Vincent’s University Hospital; (iii) Jonathan Swift Clinic, St James’s Hospital referred residents to Acute Psychiatric Unit, Tallaght Hospital and; (iv) APU 5B UH Limerick; Elm Mount Unit, St Vincent’s University Hospital; South Lee MUH, Cork UH; O’Casey Rooms; DOP Our Lady’s Hospital; Laois/Offaly MHS; AMHU Cork UH; Grangemore and St Aidan’s Ward, St Otteran’s Hospital and; Ashlin Centre all referred residents to St Patrick’s University Hospital for ECT Treatment.

\(^4\) The Cluain Mhuire catchment area admits to St John of God Hospital, an approved centre in the independent sector. The HSE purchases inpatient places in this facility for Cluain Mhuire admissions. For the purpose of this report, St John of God Hospital and Cluain Mhuire data are presented together.
3.3 People receiving ECT

This section provides information about the residents to whom ECT was administered in 2021, with data from 2020 and 2019 provided for context where relevant, including age, gender, and legal status.

Demographics: Age and gender

Figure 3 shows the gender of residents who were administered ECT between 2019 and 2021. Approximately 63% of ECT residents on average each year were female, which is consistent with other ECT jurisdictions.

The average age of residents who were administered ECT in 2021 was 65 years, with an age range of 23 to 94 years of age. In 2020 and 2019, the average age of ECT residents was 62 years and 59 years of age respectively. The data suggest that the average age of residents receiving ECT treatment is increasing year on year, a trend which will continue to be monitored by the MHC.

Figure 4 shows the age range distribution by gender of residents receiving ECT.

---

4 Scottish ECT Accreditation Network, 2019; Scottish ECT Accreditation Network, 2020; Scottish ECT Accreditation Network (SEAN), 2021.)
### Legal status

Legal status as recorded on the ECT Register relates to resident legal status when they commenced the programme of ECT: voluntary, involuntary, ward of court or outpatient.

Table 8 shows that in 2021, **81.8%** of ECT programmes were administered to residents with a voluntary legal status. In 2020, **78.3%** of programmes of ECT were administered to residents who were admitted on a voluntary basis when they commenced their programme of ECT. In 2021, **16.8%** of programmes were commenced when the legal status of the patient was involuntary, compared to **20.1%** of residents in 2020.

#### Table 8: Programmes of ECT by residents’ legal status

<table>
<thead>
<tr>
<th>Legal Status</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary</td>
<td>82.0%</td>
<td>78.3%</td>
<td>81.8%</td>
</tr>
<tr>
<td>Involuntary</td>
<td>17.5%</td>
<td>20.1%</td>
<td>16.8%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>0.0%</td>
<td>0.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Ward of Court</td>
<td>0.5%</td>
<td>1.3%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

A programme of ECT may run over a number of weeks or months, meaning that there is potential for a resident’s legal status to change during the course of the programme. Table 9 shows that a change in legal status was reported in relation to **17 programmes of ECT** in 2021, compared to **14 in 2020 and 16 in 2019**. A change from involuntary to voluntary legal status was the most common change in each of the three years.

#### Table 9: Programmes of ECT with change in legal status

<table>
<thead>
<tr>
<th>Change</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involuntary to voluntary</td>
<td>14</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Voluntary to involuntary</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Involuntary to Ward of Court</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Totals</td>
<td>16</td>
<td>14</td>
<td>17</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total changes to legal status</td>
<td>396</td>
<td>300</td>
<td>296</td>
</tr>
</tbody>
</table>

### 3.4 Administration of ECT treatment without consent

ECT cannot be administered without consent to a voluntary patient. Section 59 of the 2001 Act provides that two consultant psychiatrists can authorise and approve a treatment of ECT to an involuntary patient who has been assessed as being unable to consent to the treatment.\(^5\) The two consultants must be satisfied, following assessment, that the patient is not capable of understanding the nature, purpose and likely effects of the proposed treatment.\(^6\) The authorisation and approval is made on a specified statutory form (Form 16),\(^7\) which includes the capacity assessment and intended benefit of the treatment. The Form must be placed in the patient’s clinical file and a copy submitted to the MHC for each programme of ECT.

#### Treatments without consent

Informed consent must be sought prior to the commencement of a programme of ECT, and in advance of every ECT treatment. The capacity of a patient to consent may change over the duration of the programme and must be assessed in advance of every treatment. A programme of ECT may therefore involve one or more treatments of ECT without consent. Table 10 shows that **14% of programmes had one or more treatments without consent** in 2021, a reduction on 18% in 2020 and 16% in 2019. Furthermore, **296 individual treatments (13%)** of ECT were administered without consent in 2021, lower than in both 2020 (442 treatments, 19%) and 2019 (516, 16%). The data indicate that the administration of ECT without consent to residents has decreased over the past three years.

#### Table 10: Programmes of ECT with one or more treatments without consent

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programmes without consent</td>
<td>Number</td>
<td>% of total</td>
<td>15.9%</td>
</tr>
<tr>
<td>Treatments without consent</td>
<td>Number</td>
<td>% of total</td>
<td>16.5%</td>
</tr>
</tbody>
</table>

In 2016 and 2017, 71 ECT clinics across England, Ireland, Wales and Northern Ireland submitted data to the ECT Accreditation Service (2017). Forty-two percent (42%) of people who underwent an acute

---

\(^5\) Section 59 Mental Health Act 2001-2018.

\(^6\) Section 60 Mental Health Act 2001-2018.

\(^7\) Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent.
The Administration of Electro-Convulsive Therapy in Approved Centres

In 2021, 87% of programmes of ECT (257) were administered to residents with a mood/affective disorder diagnosis (including depressive and manic disorders), followed by 7% with a diagnosis of schizophrenic, schizotypal and delusional disorders (20). In 2020, 80% of programmes of ECT administered to residents with a diagnosis of a mood disorder, while 12% of individuals had a diagnosis of schizophrenic, schizotypal and delusional disorders.

This is in keeping with other jurisdictions, as depressive disorders are the most common indication for ECT internationally (Scottish ECT Accreditation Network, 2020; Scottish ECT Accreditation Network, 2021).

Other primary diagnoses in 2021 and 2020 included neuroses, organic disorders and developmental disorders, as well as disorders of adult personality and behaviour.

Figure 5 shows the breakdown of diagnoses between the years 2019 and 2021.

**3.5 Reasons for and outcomes of ECT use**

This section provides information on the diagnoses of residents who are administered ECT, indications for ECT use, outcomes of the treatment and reasons for ending a programme of ECT.

**Diagnosis**

In 2021, 87% of programmes of ECT (257) were administered to residents with a mood/affective disorder diagnosis (including depressive and manic disorders), followed by 7% with a diagnosis of schizophrenic, schizotypal and delusional disorders (20). In 2020, 80% of programmes of ECT administered to residents with a diagnosis of a mood disorder, while 12% of individuals had a diagnosis of schizophrenic, schizotypal and delusional disorders.

This is in keeping with other jurisdictions, as depressive disorders are the most common indication for ECT internationally (Scottish ECT Accreditation Network, 2020; Scottish ECT Accreditation Network, 2021).

Other primary diagnoses in 2021 and 2020 included neuroses, organic disorders and developmental disorders, as well as disorders of adult personality and behaviour.

Figure 5 shows the breakdown of diagnoses between the years 2019 and 2021.

**Figure 5: Programmes of ECT by diagnosis**

- **Mood (Affective) Disorders**
  - 2019: 85%
  - 2020: 80%
  - 2021: 87%

- **Schizophrenia, schizotypal and delusional disorders**
  - 2019: 11%
  - 2020: 12%
  - 2021: 7%

- **Neurotics, stress-related and somatoform disorders**
  - 2019: 2%
  - 2020: 4%
  - 2021: 2%

- **Other**
  - 2019: 2%
  - 2020: 4%
  - 2021: 4%
Indications for ECT

Table 11 shows the breakdown of indications for programmes of ECT between 2019 and 2021.

Refractory (resistant) to medication was the most common single indication for ECT in the last 3 years, accounting for 62% of indications in 2021, 64% in 2020 and 66% in 2019. Maintenance ECT (19%) was the second most common indication in 2021, followed by Rapid response required (10%).

Table 11: Indications for ECT

<table>
<thead>
<tr>
<th>Indications</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refractory to medication</td>
<td>259</td>
<td>193</td>
<td>184</td>
</tr>
<tr>
<td>Multiple or ‘other’ indications¹</td>
<td>8</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Maintenance ECT</td>
<td>47</td>
<td>38</td>
<td>55</td>
</tr>
<tr>
<td>Rapid response required</td>
<td>52</td>
<td>38</td>
<td>30</td>
</tr>
<tr>
<td>Acute suicidality</td>
<td>13</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Physical deterioration</td>
<td>14</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Total Programmes</td>
<td>395</td>
<td>300</td>
<td>296</td>
</tr>
</tbody>
</table>

¹ Indications labelled ‘other’ did not include additional information

Reason for ending a programme of ECT

The consultant psychiatrist responsible for the care and treatment of the resident must record the reason for ending a programme of ECT on the ECT Register. Table 12 provides a breakdown of each reason for terminating a programme of ECT between 2019 and 2021.

Improvement was reported as the reason for ending the majority of programmes of ECT in 2021, accounting for 61% of programmes, a slight reduction from 63% of programmes in 2020. In 2021, 15% of programmes ended after 12 treatments were administered, compared to 10% of programmes in 2020. Programmes of ECT ended because the resident withdrew consent in 5% and 6% of programmes in 2021 and 2020 respectively. No improvement (3%) and Complications (3%) accounted for 6% of programmes ending in 2021, while Multiple or Other reasons (13%) accounted for the remaining 2021 programmes.

Table 12: Reason for ending programme of ECT

<table>
<thead>
<tr>
<th>Reason for ending ECT</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement</td>
<td>299</td>
<td>189</td>
<td>181</td>
</tr>
<tr>
<td>Multiple or other¹</td>
<td>54</td>
<td>40</td>
<td>39</td>
</tr>
<tr>
<td>No improvement</td>
<td>18</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Resident withdrew consent</td>
<td>13</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td>Complications</td>
<td>9</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>12 Treatments Administered</td>
<td>0</td>
<td>31</td>
<td>43</td>
</tr>
<tr>
<td>Register not completed</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Programmes</td>
<td>395</td>
<td>300</td>
<td>296</td>
</tr>
</tbody>
</table>

¹ ‘Other’ reasons for ending programmes of ECT did not include additional information

Outcome at the end of a programme of ECT

Improvement was reported as the outcome in 87% of programmes of ECT in 2021, higher than in 2020 (86%) but lower than in 2019 (89%). Table 13 presents the outcome at the end of programmes of ECT administered from 2019 to 2021. It should be noted that the ECT programme outcome scale was amended in 2020, so a direct comparison to previous years cannot be made. However, Table 13 groups the 2019 outcomes with the 2020 and 2021 outcomes using a best-fit approach.

Much Improved or Very much Improved was reported as the outcome for 71% of ECT programmes in 2021, compared to 72% of programmes in 2020. In comparison, 75% of programmes reported moderate to significant improvement, up to complete recovery in 2019. In 2021, 17% of respondents reported being Minimally Improved, higher than in 2020 (14%), while 13% of programmes reported Some Improvement in 2019. In both 2021 and 2020, 9% of programmes reported no change, up from 5% in 2019. No programme (0%) reported a negative outcome in 2021, while negative outcomes Minimally Worse, Much Worse and Very Much Worse accounted for 1% of programmes in 2020. Similarly, Deterioration was reported in 2% of programmes in 2019.
Laterality of ECT Treatment

Laterality refers to the location of electrodes on the head of the patient during ECT treatment. In unilateral ECT, electrodes are placed on the same side of the head while in bilateral ECT, electrodes are placed on the opposite side of the head.

In 2021, almost half (49%) of ECT treatments in Ireland were unilateral, while 46% of treatments were bilateral. Five percent (5%) of programmes used a combination of unilateral and bilateral ECT.

### Table 13: Outcome at end of ECT programme

<table>
<thead>
<tr>
<th>Indications</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete recovery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Much Improved</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>24%</td>
<td>112</td>
<td>80</td>
</tr>
<tr>
<td>Significant improvement</td>
<td>153</td>
<td>37.3%</td>
<td>27.0%</td>
</tr>
<tr>
<td>39%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate improvement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Much Improved</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>104</td>
<td>129</td>
<td></td>
</tr>
<tr>
<td>13%</td>
<td>34.7%</td>
<td>43.6%</td>
<td></td>
</tr>
<tr>
<td>Some improvement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimally Improved</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>41</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>13%</td>
<td>13.7%</td>
<td>16.6%</td>
<td></td>
</tr>
<tr>
<td>No change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>28</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>5%</td>
<td>9.3%</td>
<td>9.1%</td>
<td></td>
</tr>
<tr>
<td>Deterioration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimally Worse</td>
<td>6</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>1%</td>
<td>1.0%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Much Worse</td>
<td></td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>0.3%</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Very Much Worse</td>
<td></td>
<td>2%</td>
<td>0</td>
</tr>
<tr>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Register Not Completed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>18</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5%</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td></td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>0%</td>
<td>0.7%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td></td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>3.0%</td>
<td>0.7%</td>
<td>0.0%</td>
<td></td>
</tr>
</tbody>
</table>

| Total                |      |      |      |
| 395                  | 300  | 296  |

### Table 14: Laterality of ECT programmes

<table>
<thead>
<tr>
<th>Laterality</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unilateral</td>
<td>49%</td>
</tr>
<tr>
<td>Bilateral</td>
<td>46%</td>
</tr>
<tr>
<td>Unilateral and Bilateral</td>
<td>5%</td>
</tr>
</tbody>
</table>
Chapter 4

Compliance with ECT Rules and Code of Practice
COMPLIANCE WITH ECT RULES AND CODE OF PRACTICE

The Inspector of Mental Health Services visits and inspects every approved centre at least once a year. As part of this inspection, the Inspector rates compliance against the Rules and Code relating to ECT, as applicable.

It is important to note that Part 2 of the Rules deals with the issue of consent to treatment and provides safeguards for situations where the patient is unable to consent. The MHC carries out inspections of all approved centres where ECT is provided and seeks evidence that these safeguards are followed (see Section 3.4 for more information).

In 2021, the Inspector of Mental Health Services inspected 9 approved centres for compliance with the Rules Governing the Use of Electro-Convulsive Therapy (the ‘Rules’) and the Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients (the ‘Code’).

Compliance with Rules Governing the Use of ECT

Figure 6 outlines the compliance rates of approved centres with the Rules between 2019 and 2021. In 2021, all 9 applicable approved centres were compliant with the Rules (100%). This is an improvement on 2020, where 10 of the 13 applicable services were compliant with the Rules. Of the 3 non-compliant approved centres in 2020, 1 had a moderate risk rating, while 2 were rated as high risk. In 2019, only 5 of the 11 approved centres (45%) were compliant with the Rules. Of the 6 non-compliant approved centres in 2019, 1 had a low-risk rating, 4 had a moderate risk rating, and 1 was risk rated as critical. The data indicate that compliance with the ECT Rules has improved over the past number of years.

Reasons for non-compliance in 2020 and 2019 for both the Rules and Code are similar and include:

- The prescription of ECT did not include the alternative therapies that were considered or had proved ineffective.
- There was no documentary evidence that a cognitive assessment was completed before the programme of ECT.
- The approved centre did not have a named consultant anaesthetist with overall responsibility for anaesthesia.

Further details on approved centre compliance can be found at: mhcirl.ie/what-we-do/regulation/approved-centres/

Figure 6: Relevant approved centre compliance with Rules Governing the Use of Electro-Convulsive Therapy, 2019 – 2021
Compliance with ECT Code of Practice

Figure 7 shows the numbers of approved centres compliant with the Code on ECT between 2019 and 2021. In 2021, all applicable approved centres were compliant with the Code (100%). In 2020, 12 of 14 services were compliant. One non-compliant centre had a moderate risk rating while the other had a high-risk rating. In 2019, 13 out of 16 approved centres were compliant with the Code. All three non-compliant centres had a moderate risk rating. As with the ECT Rules, the data indicate that compliance with the ECT Code has improved in recent years.

**Figure 7: Relevant approved centre compliance with Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, 2019 – 2021**

![Bar chart showing compliance with ECT Code of Practice from 2019 to 2021](chart.jpg)
Discussion
DISCUSSION

This report is being issued 13 years after the publication of the first annual Report on the Use of Electroconvulsive Therapy in Approved Centres in 2008 (2009). In light of this, a comparison and trend visualisation in the use of ECT in approved centres between 2008 and 2021 is outlined in the following graphs in relation to:

i. The number of residents who underwent ECT

ii. The number of programmes and treatments administered per year

iii. Outcomes of ECT treatment

iv. The gender balance of residents who were administered ECT

v. Indications for the use of ECT treatment

vi. The percentage of residents who were diagnosed with a depressive disorder prior to undergoing ECT treatment

vii. The outcomes observed from ECT treatments from 2008 to 2021

viii. The average age of residents undergoing ECT treatment.

Figures 8 and 9 indicate that in relation to the number of residents undergoing ECT treatment and the number of programmes of ECT, there has been an overall decrease since 2008. A general increase in residents and programmes is visible between 2015 and 2019, which may indicate that more residents underwent the full complement of treatments per programme during that period compared to previous years. There was a noticeable decrease in 2020 and 2021, however. The COVID-19 pandemic may have played a factor in the availability and administration of ECT programmes in the past two years. Further research is required to make any definitive findings in this regard.

Figure 8: Comparison of number of residents and programmes in approved centres, 2008-2021
Figure 9: Comparison of number of ECT treatments per year, 2008–2021

Figure 10 outlines the total inpatient mental health service admissions recorded by the Health Research Board between the years 2008 and 2021, compared to the numbers of patients involuntarily admitted to inpatient mental health services over the same period. Involuntary admissions have increased year-on-year from 2,004 to 2,673 over the fourteen-year period, while total admissions have fallen considerably, from 20,752 at its highest in 2008 to 15,723 in 2021.

Figure 10: Comparison of total admissions to involuntary admissions, 2008–2021
Figure 11: Comparison of gender of residents who were administered ECT, 2008–2021

Figure 12: Comparison of indications for use of ECT, 2008–2021
Figure 11 shows that the ratio of female to male residents administered ECT remained fairly static (approximately 2:1) between 2008 and 2020. As previously discussed, this may be as a result of the relatively higher rate of diagnosed mood disorders in women than men in Ireland. However, there was a significant increase in the number of male residents receiving ECT treatment in 2021, where 41% of residents who underwent treatment were male compared to an average of 35% between 2008 and 2020. Factors leading to the increase in the number of males receiving ECT treatment in 2021 are unknown, and it remains to be seen whether this trend continues into the future.

Figure 12 shows that since 2008, the most common indication for the use of ECT treatment has consistently been that the residents are refractory, or resistant, to medication. On average, refractory to medication has been the indication for use of ECT in 58% of programmes between 2008 and 2021.

As discussed in Section 3.5, the ECT programme outcome scale was amended in 2020. Figure 14 below compares the ECT programme outcomes from 2008 to 2021, using the newly defined outcomes and a best-fit approach. The graph shows that Very Much Improved has been the most consistent ECT programme outcome. It should be noted that on the graph, the Very Much Improved outcome between 2008 and 2019 is a combination of two legacy outcomes: Significant Improvement and Complete Recovery. This explains the visible dip in the curve in 2020 and 2021. The next most frequent outcomes were Much Improved and Minimally Improved. Data from 2021 and 2020 indicate that Much Improved is increasing as a programme outcome, while Very Much Improved is decreasing. Programmes that reported No Change or Minimally Worse to Very Much Worse outcomes were significantly less common. This trend would indicate that ECT treatment generally has a positive effect on those being treated. However, it is not clear what weight external factors such as diagnosis, age and acuity have on the aggregate effectiveness of the treatment, and how ECT weighs up against traditional medication or alternative methods.

Figure 13: Comparison of programmes of ECT by diagnosis, 2008–2021

![Comparison of programmes of ECT by diagnosis, 2008–2021](image-url)
Figure 15 indicates that the average age of residents receiving ECT rose between 2010 (the first year that the age of ECT residents was collected from approved centres) and 2021, from 57 to 65 years of age. It is unclear why the age of ECT residents is increasing, and further research is required. A reason suggested for the elevated average age of ECT users, as compared with the average age of residents admitted to Irish hospitals generally (including approved centres) (45 years\textsuperscript{8}) is that ECT tends to be in most cases, and as outlined in Figure 12 above, a last-resort treatment for people suffering from mental disorders who have been unresponsive or refractory to alternative treatments and medication for a considerable period of time.

Conclusion
CONCLUSION

The aim of collecting data in relation to the use of ECT in approved centres is to report on the administration of ECT as captured by each approved centre and submitted to the MHC. There are limitations, on the basis of data protection, which restrict the amount of information that can legally be requested. Other information could, in theory, make a comparative analysis more useful. This might include:

1) geographic area or address, as the majority of ECT is administered in national services and data on the location of residents is not included; and

2) long-term recovery or improvement statistics collected from residents who underwent ECT treatments, at 6-month, 1-year and 5-year increments.

Furthermore, and in support of the HIQA recommendation (Health Information and Quality Authority, 2009), a national system of unique health identifiers (UHIs) for patients would provide for a more detailed data analysis of ECT programmes in Ireland, while protecting patient confidentiality. Considering these limitations, it is neither useful nor practicable to offer recommendations based on the results of the data collected, nor to make either a positive or negative statement about the impact and usefulness of ECT treatment.
References


Appendices
APPENDIX 1: CIS215 - ECT NOTIFICATION SCREEN AND FORM 16
Form 16: Treatment Without Consent Electro-Convulsive Therapy Involuntary Patient (Adult) forms relating to patients who were unable to consent to ECT treatment. Effective from 15 February 2016

<table>
<thead>
<tr>
<th>1. Full Name of Patient</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Date of Birth</td>
<td>Gender M [ ] F [ ]</td>
</tr>
<tr>
<td>3. Name and Address of Approved Centre to which the patient was admitted</td>
<td></td>
</tr>
<tr>
<td>4. Date</td>
<td></td>
</tr>
<tr>
<td>5. Full Name of Responsible Consultant Psychiatrist (and Professional Address if other than Section 3 above)</td>
<td></td>
</tr>
<tr>
<td>6. Give details of how this treatment will benefit the patient</td>
<td></td>
</tr>
<tr>
<td>7. Give details of discussion with and views expressed by the patient</td>
<td></td>
</tr>
<tr>
<td>8. Give details of assistance, if any, provided to the patient in relation to discussion</td>
<td></td>
</tr>
<tr>
<td>9. Give details of your assessment of the patient's ability to consent to treatment</td>
<td></td>
</tr>
</tbody>
</table>

**To be completed by the consultant psychiatrist responsible for the care and treatment of the Patient:**

**BLOCK CAPITALS** (Before completing this form, please read the notes overleaf)

I have examined the above named patient on (date) and I am of the opinion that it would be to the benefit of the patient to be administered electroconvulsive therapy for the following reasons

__SIGNATURES REQUIRED ON PAGE 3__

For use only in accordance with the Mental Health Act 2001 (as amended). Penalties apply for giving false or misleading information.
To be completed by the consultant psychiatrist responsible for the care and treatment of the Patient:

This patient is unable to give consent to this treatment.

I approve this programme of electroconvulsive therapy. □

Signed: __________________________ MCRN: __________________________

(Responsible Consultant Psychiatrist)

Date: __/__/____ (24 hour clock e.g. 2.41 p.m. is written as 14:41)

Time: __:__:--

This part to be completed by another consultant psychiatrist following referral by the first-mentioned psychiatrist.

10. Full Name of Consultant Psychiatrist (and Professional Address if other than Section 3 above)

I have examined the above named patient on DATE: __/__/____ and I am of the opinion that it would be to the benefit of the patient to be administered electroconvulsive therapy for the following reasons

11. Give details of how this treatment will benefit the patient

12. Give details of discussion with and views expressed by the patient

13. Give details of assistance, if any, provided to the patient in relation to discussion

14. Give details of your assessment of the patient’s ability to consent to treatment

This patient is unable to give consent to this treatment.

I authorise this programme of electroconvulsive therapy. □

Signed: __________________________ MCRN: __________________________

(Consultant Psychiatrist)

Date: __/__/____ (24 hour clock e.g. 2.41 p.m. is written as 14:41)

Time: __:__:--

For use only in accordance with the Mental Health Act 2001 (as amended). Penalties apply for giving false or misleading information.
Form 16 Treatment Without Consent Electro-convulsive Therapy involuntary patient (adult)

Please complete the information below electronically in relation to the attached Form 16 and return by email: mentalhealthdata@mhcirl.ie

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Approved Centre Name</td>
</tr>
<tr>
<td>2.</td>
<td>Form ID number:</td>
</tr>
<tr>
<td>3.</td>
<td>Did this programme of ECT without consent proceed?</td>
</tr>
<tr>
<td></td>
<td>(if no you do not need to complete the remaining questions)</td>
</tr>
<tr>
<td></td>
<td>Yes [ ] No [ ]</td>
</tr>
<tr>
<td>4.</td>
<td>Was this patient (please select response a or b or c)</td>
</tr>
<tr>
<td>a)</td>
<td>A patient of this Approved Centre who was administered ECT in this Approved Centre?</td>
</tr>
<tr>
<td></td>
<td>Or</td>
</tr>
<tr>
<td>b)</td>
<td>A patient of another Approved Centre who was referred here for ECT treatment? (if yes please specify name of other Approved Centre)</td>
</tr>
<tr>
<td></td>
<td>Or</td>
</tr>
<tr>
<td>c)</td>
<td>A patient of this Approved Centre who was referred to another Approved Centre for ECT treatment? (if yes please specify the name of the other Approved Centre)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX 2: ICD 10 CODES AND DIAGNOSTIC GROUPS

<table>
<thead>
<tr>
<th>ICD-10 diagnostic groups</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Organic disorders</td>
<td>F00-F09</td>
</tr>
<tr>
<td>2. Alcoholic disorders</td>
<td>F10</td>
</tr>
<tr>
<td>3. Other drug disorders</td>
<td>F11-F19, F55</td>
</tr>
<tr>
<td>4. Schizophrenia, schizotypal and delusional disorders</td>
<td>F20-F29</td>
</tr>
<tr>
<td>5. Depressive disorders</td>
<td>F31.3, F31.4, F31.5, F32, F33, F34.1, F34.8, F34.9</td>
</tr>
<tr>
<td>6. Mania</td>
<td>F30, F31.0, F31.1, F31.2, F31.6, F31.7, F31.8, F31.9, F34.0</td>
</tr>
<tr>
<td>7. Neuroses</td>
<td>F40-F48</td>
</tr>
<tr>
<td>8. Eating disorders</td>
<td>F50</td>
</tr>
<tr>
<td>9. Personality and behavioural disorders</td>
<td>F60-F69</td>
</tr>
<tr>
<td>10. Intellectual disability</td>
<td>F70-F79</td>
</tr>
<tr>
<td>11. Development disorders</td>
<td>F80-F89</td>
</tr>
<tr>
<td>12. Behavioural and emotional disorders of childhood</td>
<td>F90-F98</td>
</tr>
</tbody>
</table>